MCF_Fav_SB 707.pdf
Uploaded by: Ann Geddes
Position: FAV

SB 707 – Health Insurance – Provider Panels – Coverage for Non-participation

Committee: Senate Finance Committee
Date: February 23, 2022
POSITION: Support

The Maryland Coalition of Families: Maryland Coalition of Families (MCF) helps families who care for a loved one with behavioral health needs. Using personal experience, our staff provide one-to-one peer support and navigation services to family members with a child, youth or adult with a mental health, substance use or gambling issue.

MCF strongly supports SB 707.

We know that the mental health of children has been particularly hard hit during the COVID-19 pandemic. The CDC reported that the proportion of mental health-related ED visits increased sharply beginning in mid-March 2020 and continued into October (the study was completed in November 2020) with increases of 24% among children aged 5-11 years and 31% among adolescents aged 12-17 years, compared with the same period in 2019. Other indicators too show that the mental health of children has worsened during the pandemic. In the fall of 2021, a coalition of the nation's leading experts in pediatric health declared a national emergency in child and adolescent mental health.

Therefore not surprisingly, the number of families that have tried to access mental health treatment for their child has grown tremendously compared to pre-pandemic times. We often hear that parents/caregivers of children with private insurance have been told again and again, upon calling their carrier's in-network providers, that the providers are not taking new patients. At best, children wait for months on waiting lists to access mental health treatment. Families do not know that they have the right to request from their insurer that their child be allowed to see an out-of-network provider if no in-network provider can be found within a reasonable time and distance.

Not only do parents not know that they have this right, if they exercise that right they can be charged significantly more than their normal co-pay. The carrier bears no financial responsibility for having an inadequate network of providers.

SB 707 would remedy this unfair situation. First, families would be explicitly and clearly told that they have the right to see an out-of-network provider, and second, they would not bear

significant additional costs to exercise the right. Children would be able to access the mental health treatment that they so desperately need in a timely fashion.

For these reasons we request a favorable report on SB 707.

Contact: Ann Geddes
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SB0707_FAV_MdCSWC_HI - Provider Panels - Coverage
Uploaded by: Christine Krone
Position: FAV

MdCSWC **The Maryland Clinical Social Work Coalition**

The MdCSWC, sponsored by the Greater Washington Society for Clinical Social Work, represents the interests of more than 9,500 licensed clinical social workers in Maryland.

TO: The Honorable Delores G. Kelley, Chair
Members, Senate Finance Committee
The Honorable Katherine Klausmeier

FROM: Judith Gallant, LCSW-C, Chair, Maryland Clinical Social Work Coalition

DATE: February 23, 2022

RE: **SUPPORT** – Senate Bill 707 – *Health Insurance – Provider Panels – Coverage for Nonparticipation*

The Maryland Clinical Social Work Coalition (MdCSWC), sponsored by the Greater Washington Society for Clinical Social Work, represents the interests of more than 9,500 licensed clinical social workers in Maryland. On behalf of MdCSWC, we **support** Senate Bill 707.

Ensuring that individuals have access to critical mental health and substance use disorder treatment services continues to be an area of concern to the clinical social work community. Recent reports from the Maryland Insurance Administration have confirmed the inadequacy of some carrier's networks. Senate Bill 707 addresses this issue in a manner that will assist in fostering adequate networks and/or adequate payment to these specialists. It also ensures that the insured has coverage for mental health or substance use disorder services at no greater cost to the member than if the services were provided in-network by allowing an insured to go out of network if the carrier's provider panel has an insufficient number or type of participating specialist or nonphysician specialist for the required services. MdCSWC strongly urges a favorable report.

For more information call:
Pamela Metz Kasemeyer
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SB707_Cbergan_Fav.pdf
Uploaded by: Courtney Bergan
Position: FAV

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February 23, 2022

The Honorable Delores G. Kelley, Chair
Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

Favorable SB 707: Health Insurance – Provider Panels – Coverage for Nonparticipation

Dear Chair Kelley and Members of the Committee:

I urge you to support Senate Bill 707 as a concerned Maryland resident and a student at the University of Maryland Francis King Carey School of Law. But more importantly in this context, I am an individual living with a mental health condition and my inability to access appropriate mental health care within my insurers' provider networks nearly cost me my life. Gaining access to mental health services mandated under Maryland law[1] required me to spend an inordinate amount of time and energy advocating with insurers to simply negotiate payment for care my insurers authorized me to obtain from out-of-network providers. My eventual ability to obtain access to appropriate and affordable mental health care changed my life, allowing me to return to school, reducing my overall healthcare costs, and granting me access to opportunities I never imagined possible. I support SB 707 because every Marylander deserves the opportunity to thrive.

Mental health and substance use disorders are treatable conditions.[2] No one should go without care or lose their life simply because their insurance company fails to offer appropriate in-network care. Existing law already requires insurers to cover out-of-network mental health and substance use disorder services when appropriate care is not available within an insurance carrier's provider network.[3] Nonetheless, many continue to be denied access to lifesaving mental health and substance use disorder services because insurers' refuse to negotiate payment for these mandated benefits.[4]

In my case, I made every effort to obtain mental health services within my insurer's network. I spent four months contacting more than 50 mental health providers, yet not one in-network provider had the availability, willingness, and expertise to treat my condition. Because many providers deemed me "high-risk" due to my history of repeated trauma and hospitalizations in conjunction with having a rare, complex medical condition, obtaining access to appropriate mental health care is complicated. Nonetheless, appropriate care exists, but it is often not available within many insurer networks, because reimbursement isn't commensurate with the time and expertise required to provide adequate mental health care to "high-risk" patients.[5]

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[1] *See* Md. Code Ann., Ins. § 15-830 (d) (2019).
[2] U.S. Dept. of Health and Human Serv., Mental Health Treatment Works, https://www.samhsa.gov/mental-health-treatment-works.
[3] *See* Md. Code Ann., Ins. § 15-830 (d)(2)(ii) (2019).
[4] NAMI, *Health Insurers Still Don't Adequately Cover Mental Health Treatment* (Mar. 13, 2020), https://www.nami.org/Blogs/NAMI-Blog/March-2020/Health-Insurers-Still-Don-t-Adequately-Cover-Mental-Health-Treatment.
[5] A 2020 Milliman report indicated only 4.4% of healthcare spending goes towards behavioral health care. Stoddard Davenport, Et al., *How do individuals with behavioral health conditions contribute to physical and total healthcare spending?* 6–11 (2020), https://www.milliman.com/-/media/milliman/pdfs/articles/milliman-high-cost-patient-study-2020.ashx.

When I finally located a provider willing to assume my care, they didn't participate with my insurer's provider network. However, the provider agreed to try to negotiate a single case agreement with my insurance carrier. Thus, I contacted my insurer to request a single case agreement and they authorized me to seek out-of-network mental health care under an existing Maryland statute.[6] While my insurer authorized me to obtain out-of-network mental health services because they acknowledged appropriate care wasn't available within the carrier's network, my insurer refused to negotiate payment with my provider. Consequently, even with an authorization allowing me to access out-of-network care at my in-network co-pay, obtaining that care remained financially untenable because existing law fails to address either carrier reimbursement or balance billing for such authorizations.[7]

Because of this loophole in existing law, I spent hours on the phone with my insurance carrier for several consecutive weeks just trying to navigate payment to my psychologist. When I would call the carrier to follow up on negotiating payment with my psychologist under the authorization they provided, my insurer would either send me on a wild goose chase contacting in-network providers who weren't qualified to treat my condition or tell me they wouldn't negotiate a rate under the authorization provided. In fact, on one occasion a customer service representative readily acknowledged that utilizing the carrier's authorization to seek out-of-network mental health care would cost me more than utilizing my out-of-network benefits. When I raised concerns about this disparity, I was told it was "just part of the business," even though the practice seemed to contravene the legislative intent of existing Maryland law. [8]

Both my provider and I were ready to give up as a result of the barriers my insurance carrier continually placed in the path of finalizing a single case agreement. However, giving up wasn't an actual choice: my life depended on access to appropriate mental health care. Thus, I desperately contacted the Health Education and Advocacy Unit at the Attorney General's Office and numerous outside entities for assistance with navigating this process. Only after I testified before the Senate Finance Committee on March 13, 2019, regarding a previous iteration of this bill,[9] did my insurer finally agree to negotiate payment under a single case agreement with my psychologist, nearly two months after the initiation of the request.

Yet, less than six months after that single case agreement was finalized, my school unexpectedly switched insurance carriers. As a result, I had to start the entire single case agreement process over again with my new carrier. However, the second time around resulted in even more dire consequences, leading to prolonged hospitalization because I couldn't be released until the hospital knew I had access to appropriate outpatient care. Again, my new insurer refused to negotiate payment with my outpatient mental health providers for services that the hospital required I have in place before I could discharge home. As result of my new insurer's refusal to negotiate with my providers, my education was interrupted, and my insurer incurred over $135,000 in hospital costs. Eventually, my insurer agreed to negotiate single case agreements with my outpatient providers. Notably, my new insurance carrier opted to pay my providers' full billed rate rather than negotiate.

Nonetheless, the delay left me a year behind my graduate school cohort, required me to spend Jewish high holidays in the hospital, and unnecessarily uprooted my life. For nearly four months, I was trapped in a

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[6] *See* Md. Code Ann., Ins. § 15-830 (d)(2) (2019).
[7] *See* Md. Code Ann., Ins. § 15-830 (e) (2019).
[8] *See* Md. Code Ann., Ins. § 15-830 (e) (2019).
[9] *See* 2019 Maryland Senate Bill No. 761, Maryland 439th Session of the General Assembly, 2019.

hospital, uncertain whether I would continue to have access to the mental health services I had just fought so hard to obtain.

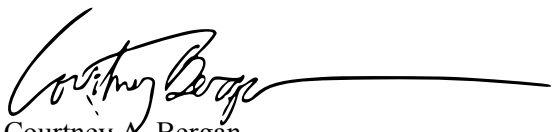
I was fortunate to encounter some incredible advocates who helped me gain access to the care I needed under my new insurance. Without their assistance, I wouldn't have access to the life changing mental health care I have today. Yet, obtaining access to state mandated benefits shouldn't be a full-time job for consumers or providers in the first place. When I compare my experiences seeking mental health care to those seeking care for complex medical conditions, I've never faced such repeated, prolonged ordeals obtaining access to medical care: care that is ten times more expensive than the mental health services I sought coverage for.[10]

Most importantly, access to appropriate mental health care changed my life in ways I never imagined possible. Before I began seeing my current providers, I was told I was "hopeless." Those messages were decidedly wrong,[11] but I never would have had the opportunity to learn that without my current mental health providers. I am now in my second year of law school, and I recently completed the fall semester with a 4.06 GPA. I just founded an organization to support disabled law students at the University of Maryland and I am active in many other University committees and community organizations. I have a stable place to live, supportive friends, and I haven't required hospitalization since the last time my insurer refused to provide access to appropriate mental health care. These are all achievements that once seemed out of reach.

I now have life that is beyond my wildest dreams because I was finally able to access appropriate and affordable mental health care. But now, I am left wondering how many other Marylanders are robbed of opportunities because their insurer refuses to provide access to the mental health and substance use disorder services they are entitled to under the law? I could go on about the economic benefits of Senate Bill 707, which ensures other Marylanders can access appropriate and affordable mental health and substance use disorder services. Yet, the value of human lives can't be reduced to economics. We can't continue to allow insurers' profits to come before Marylanders' lives.

I support Senate Bill 707 because Marylanders shouldn't have to sacrifice their lives when an insurer fails to provide access to appropriate mental health and substance use disorder services.

Sincerely,



Courtney A. Bergan
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[10] A 2020 Milliman report found that people with behavioral health conditions accounted for 56.5% of healthcare costs, yet behavioral health care accounts only 4.4% of total healthcare costs. Stoddard Davenport, Et. al., *How do individuals with behavioral health conditions contribute to physical and total healthcare spending?* 6–11 (2020), https://www.milliman.com/-/media/milliman/pdfs/articles/milliman-high-cost-patient-study-2020.ashx.

[11] Psychotherapy is an underutilized treatment with minimal side effects that leads to improved long term health outcomes. Press release, American Psychological Association, *Research shows psychotherapy is effective but underutilized*. (August 9, 2012), http://www.apa.org/news/press/releases/2012/08/psychotherapy-effective.

SB0707 balance billing.pdf
Uploaded by: Dan Martin
Position: FAV

mhamd
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Senate Bill 707 Health Insurance - Provider Panels - Coverage for Nonparticipation
Health and Government Operations Committee
February 23, 2022
Position: SUPPORT

The Mental Health Association of Maryland is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health, mental illness and substance use. We appreciate this opportunity to present this testimony in support of Senate Bill 707.

SB 707 will improve access to care by preventing commercially insured Marylanders from being billed extra when they are forced to go out-of-network for behavioral health treatment.

The Maryland General Assembly and the Maryland Insurance Administration have taken important steps over the years to address network adequacy concerns and improve access to treatment for individuals with mental health and substance use disorders. Unfortunately, these efforts have yet to ensure that Marylanders with commercial insurance can access in-network behavioral health care when needed.

An independent national report[1] published in late 2019 cast a harsh light on the situation. According to the data, Maryland is among the worst states for access to affordable in-network behavioral health services. It demonstrates that insurers in Maryland are much more likely to provide in-network care for physical health services compared to mental health and substance use treatment services. This limits access to care and results in higher out-of-pocket costs that can make treatment unaffordable, even for those with insurance.

Key findings are as follows (see attached infographic for more details):

- Marylanders were 10 times more likely to go out-of-network for behavioral health visits compared to primary care. This rate is twice the national average and **fourth worst in the nation**.

- Out-of-network inpatient behavioral health use rose from 5.5 times to 9.3 times more likely than for medical/surgical services between 2013 and 2017. This rate is also nearly **twice the national average**.

- Reimbursement rate for Maryland psychiatrists in 2017 was **18% less** than other physicians for the same billing codes.

[1] Melek, Stephen P.; Gray, Travis J. (T.J.); Davenport, Stoddard. Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement. Milliman, Inc. November 2019.
https://www.milliman.com/insight/Addiction-and-mental-health-vs-physical-health-Widening-disparities-in-network-use-and-p

For more information, please contact Dan Martin at (410) 978-8865

Commercially insured Marylanders face enormous challenges when attempting to access community mental health and substance use treatment. Progress has been made, but there is much work to be done. Until we address these outstanding network adequacy failures, we must ensure that Marylanders forced to go out-of-network for behavioral health care are not penalized for doing so. **For these reasons, MHAMD supports SB 707 and urges a favorable report.**

MARYLAND PROFILE
NOVEMBER 2019

mhamd
MENTAL HEALTH ASSOCIATION OF MARYLAND

NEW NATIONAL REPORT DOCUMENTS INCREASED BEHAVIORAL HEALTH DISPARITIES IN EMPLOYER SPONSORED HEALTH PLANS

A new study conducted by Milliman, Inc. covering 37 million employees and their families, commissioned by The BowmanFamily Foundation, reflects dramatically worsened access to behavioral health care since a similar study was publishedtwo years ago.

- Despite the National Opioid and Suicide Crises, mental health and substance use treatment* together accountedfor less than 3.5% of total health care spend, with substance use treatment ranging from 0.7 to 1% of that total over the 5 year period.
- Behavioral health access disparities escalated from 2013 to 2017 in all three categories of care examined:outpatient visits, inpatient facilities and outpatient facilities. Disparities nearly doubled for inpatient and outpatient facilities, rising from almost 3 to nearly 6 timesmore likely, when compared to medical/surgical facility use.
- Children were 10 times more likely to receive outpatient mental health care out of network compared to primary care visits, twice the disparity faced by adults.

OFFICE VISIT ACCESS

Higher out of network for behavioral health office visits compared to primary care.

	2013	2015	2017
NATIONAL	5.04 x	5.09 x	5.41 x
MARYLAND	7.95 x	9.02 x	10.00 x

Maryland outpatient access is **4th WORST** in the nation—10 times more likely and nearly twice the national average.

INPATIENT FACILITY ACCESS

Higher out of network for behavioral health inpatient compared to medical/surgical.

	2013	2015	2017
NATIONAL	2.83 x	3.85x	5.24 x
MARYLAND	5.50 x	5.60 x	9.35 x

Maryland out of network inpatient use rose from **5.5. to 9.3 times more likely** —nearly twice the national average.

OUTPATIENT FACILITY ACCESS

Higher out of network for behavioral health outpatient facility compared to medical/surgical.

	2013	2015	2017
NATIONAL	2.97 x	5.09 x	5.72 x
MARYLAND	1.96 x	3.55 x	3.66 x

Maryland out of network outpatient facility use rose from **2 to 3.6 times more likely**.

OFFICE VISIT REIMBURSEMENT

Higher office visit reimbursement for primary care compared to behavioral health.

	2013	2015	2017
NATIONAL	20.70%	20.80%	23.80%
MARYLAND	23.20%	27.20%	18.20%

Maryland behavioral health providers **received 18% less than other doctors** for similar billing codes.

***** Excludes behavioral health prescription drugs, which were 2% of total healthcare spending in 2017.

SB0707_FAV_MedChi, MACHC_HI - Provider Panels - No
Uploaded by: Danna Kauffman
Position: FAV

MedChi

MID-ATLANTIC ASSOCIATION OF COMMUNITY HEALTH CENTERS

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TO: The Honorable Delores G. Kelley, Chair
Members, Senate Finance Committee
The Honorable Katherine Klausmeier

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Christine K. Krone

DATE: February 23, 2022

RE: **SUPPORT** – Senate Bill 707 – *Health Insurance – Provider Panels – Coverage for Nonparticipation*

On behalf of the Maryland State Medical Society and the Mid-Atlantic Association of Community Health Centers, we submit this letter of **support** for Senate Bill 707. Senate Bill 707, among other provisions, allows an insured to go out of network if the carrier's provider panel has an insufficient number or type of participating specialists or nonphysician specialists with the expertise to provide the covered mental health or substance use disorder services at no greater cost to the member than if the services were provided in-network.

Ensuring that individuals have access to critical mental health and substance use disorder treatment services continues to be an area of concern. Recent reports from the Maryland Insurance Administration have confirmed the inadequacy of some carrier's networks. Senate Bill 707 addresses this issue and will assist in fostering adequate networks and/or adequate payment to these specialists. As such, the above-referenced organizations support Senate Bill 707 and urge a favorable report.

For more information call:
Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Christine K. Krone
410-244-7000

Legal Action Center Senate Finance Testimony_SB 70
Uploaded by: Ellen Weber
Position: FAV

LEGAL ACTION CENTER

Health Insurance –Provider Panels – Coverage for Nonparticipation – SB 707
Health and Government Operations Committee Hearing
February 23, 2022
FAVORABLE

Thank you for the opportunity to submit testimony **in support of SB 707** which would expand access to affordable mental health and substance use disorder services and respond to the crisis Marylanders face in obtaining this life-saving care. This testimony is submitted on behalf of the Legal Action Center, a law and policy organization that fights discrimination, builds health equity and restores opportunities for individuals with substance use disorders, arrest and conviction records, and HIV or AIDs. In Maryland, the Legal Action Center convenes the Maryland Parity Coalition and works with its partners to ensure non-discriminatory access to mental health (MH) and substance use disorder (SUD) services through enforcement of the Mental Health Parity and Addiction Equity Act, robust network adequacy standards and enforcement, and consumer protections against high out-of-pocket costs when carrier networks are not adequate.

SB 707 responds to two issues: (1) abundant evidence that Marylanders cannot access network services for MH and SUD care as they experience **the greatest need ever for care;** and (2) unfair cost barriers to treatment for members who must obtain care from a non-network provider because of the carriers' inadequate networks and are subject to balance billing. Consumers have a right to use a non-participating provider when they cannot find an in-network provider and get approval from their carrier. **That right is meaningless if the consumer must pay extra out-of-pocket costs through no fault of their own.** Maryland law allows carriers to **shift the cost of MH and SUD services to members** who have no control over their plan networks but *cannot afford* to pay for non-network services. **As state regulators and other stakeholders take steps to improve provider networks, consumers must be held harmless from costs that carriers should bear when they do not provide mandated MH and SUD services through network providers.**

SB 707 would ensure that:

- Consumers are **informed of their right** to request approval to obtain non-network services when they cannot access in-network mental health and substance use treatment without "unreasonable delay or travel."
- Consumers with a PPO plan get the full benefit of a network service by paying **"no greater cost"** than the cost of in-network services when they get approval to go to a non-participating provider.

- Non-participating providers can rely on the use of a fair reimbursement rate formula, established by the Maryland Health Care Commission through a non-regulatory stakeholder process, so that they do not shoulder the burden of negotiating reimbursement for each patient's care and risk non-payment.

A. Consumer Protections Against Balance Billing Based on Inadequate Networks - NAIC Model Act and Seventeen (17) Other State Standards

The standard proposed in SB 707 – requiring a carrier to cover an approved non-network services **at no greater cost** to the member than if that service were provided by a network provider – is modeled on the National Association of Insurance Commissioners (NAIC)

Health Benefit Plan Network Access and Adequacy Model Act. **Seventeen (17) states** have enacted this standard and already protect consumers who are forced into this situation.

The NAIC Model Act requires carriers to:

> (C)(1)…*assure that a covered person obtains a covered benefit at an in-network level of benefits*, *including an in-network level of cost-sharing*, from a non-participating provider…when the health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person without unreasonable delay or travel….
>
> (C)(3) The health carrier shall treat the health plan services the covered person receives from a non-participating provider [when the network is insufficient] *as if the services were provided by a participating provider, including counting the covered person's cost sharing for such services toward the maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan*.

NAIC Model Act, Sec. 5(C)(1)-(3), pp. 74-5 - 74-7) (emphasis added and section number omitted).

Seventeen (17) states – Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Minnesota, Mississippi, Montana, New Hampshire, New York, South Dakota, Tennessee, Vermont, and West Virginia – have adopted standards that protect consumers from paying a greater cost for a non-participating provider's services when a carrier's network is inadequate. Attachment 1. Our neighboring state of **Delaware** explicitly requires the carrier to cover non-network providers and **prohibits those providers from balance billing**. **West Virginia** law further requires carriers to specify and inform members of the process for accessing benefits from a nonparticipating provider.

The MIA has previously offered guidance to this Committee on the carrier obligation under a "no greater cost" standard, as proposed in SB 707. Attachment 2 (October 1, 2019 Letter from Commissioner Al Redmer to Delegate Shane E. Pendergrass). To lend certainty to the reimbursement rate for non-participating providers, **SB 707 would require the Maryland Health Care Commission to develop a reimbursement formula for single case agreements and payments to the provider in PPO plans.** This will ensure that providers can spend their time treating patients, not negotiating contracts, and that they will get paid fairly for their services. **Consumers will gain better access to the timely and affordable services they already pay for and are entitled to receive.**

B. Long-standing Evidence of Inadequate Carrier Networks for Substance Use Disorder and Mental Health Services Requires Immediate Action To Ensure Affordable Care.

Maryland's policy makers have long recognized the gaps in carrier networks for providers of MH and SUD services and have taken important – yet insufficient – steps to help rectify the problem. After six (6) long years and a **one-year unprecedented loss of 2,799 lives to overdose, with a disproportionate impact on Black individuals, and 650 lives lost to suicide – Marylanders can wait no longer for carriers to meet their legal obligations**.

1. Improving Network Inclusion of MH and SUD Providers

In 2016, in response to Maryland's escalating opioid overdose deaths, the Hogan Administration offered legislation – HB 800 – to address insufficient networks of substance use disorder (and other) providers. That bill failed, and subsequent efforts to improve tracking and inclusion of network MH and SUD providers have not resolved the significant network gaps.

- **In 2017**, the General Assembly enacted legislation calling for the development of **quantitative network adequacy metrics**. The MIA established strong metrics for appointment wait time, travel

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distance and provider to enrollee ratios for MH and SUD benefits and collected carrier data **that demonstrated in both 2018 and 2019** that carriers did not have sufficient SUD and MH providers to meet the needs of their members, based on appointment wait time metrics. (Attachment 3).

- **In early 2021, the MIA issued orders against 15 carriers for failure to meet network metrics in 2019 and imposed $990,000 in penalties against the carriers: a $40,000 to $100,000 penalty against each for violations of state law, including standards for mental health and substance use disorder providers.** Remarkably, the MIA suspended all penalties pending a review of the carriers' 2021 compliance reports.[1]

- **In 2021,** while more carriers reported that they had satisfied appointment wait time metrics for non-urgent MH and SUD services, **the MIA has not completed its review of the data for accuracy or completeness.** Several carriers continue to report non-compliance or incomplete data in 2021. (Attachment 3).

    - **Aetna plans** reported that their networks satisfied the 72-hour urgent care requirement for MH and SUD services for only 64% of members and satisfied the 10-day requirement for non-urgent MH and SUD services for only 72% of members.
    - **Kaiser Permanente** reported appointment wait time data for non-urgent MH and SUD services for **only 1 month** (April -May 2021). Kaiser Permanente Ins. Co. satisfied the non-urgent MH and SUD wait time metrics for only 80.4% of consumers.
    - For all other carriers, the lack of uniform reporting methodology and the lack of transparency raise significant questions about what is being measured.

- **From 2019 through mid-2021**, the MIA convened a stakeholder process to revise the network adequacy standards and, in response to the carriers' deficient networks for MH and SUD providers and continued questions related to access to care, issued a draft proposed regulation. If adopted, the new regulations would require (1) uniform reporting methodologies and templates for all metrics, (2) more frequent reporting of appointment wait time satisfaction, (3) separate reporting of appointment wait time compliance for MH services and SUD services, (4) more granular travel distance reporting for a range of MH and SUD provider types (including child psychiatrists, addiction physicians, outpatient SUD treatment facilities), and (5) mandatory disclosure of a carrier's effort to contract with providers if it failed to meet network metrics (based on the failure of most carriers to request a waiver of the metrics and explain their efforts when they did not meet the standards).

The MIA's draft proposed regulation would lend greater clarity to the underlying cause of inadequate networks for MH and SUD providers**. Yet pending the implementation of more robust standards and greater oversight, carriers – not consumers – should shoulder the cost of life-saving MH and SUD care when their networks are inadequate.**

2. Low Reimbursement Rates for MH and SUD Providers

[1] Aetna Health, Inc. (HMO), Case No. Not Listed (March 19, 2021) ($75,000 penalty); Aetna Health and Life Insurance, Case No. Not Listed (March 19, 2021) ($75,000 penalty); Aetna Life Ins. Co., Case No. Not Listed ($75,000 penalty); Kaiser Foundation Health Plan Mid-Atlantic States, Case No. Not Listed (March 23, 2021) ($50,000 penalty); Kaiser Permanente Ins. Co., Case No. Not Listed (April 15, 2021) ($100,000); Golden Rule Ins. Co., Case No. Not Listed (April 19, 2021) ($40,000 penalty); MAMSI Life and Health Ins. Co., Case No. Not Listed (April 19, 2021) ($40,000 penalty); Cigna Health and Life Ins. Co., Case No. Not Listed (April 6, 2021) ($100,000 penalty); Optimum Choice, Inc., Case No. Not Listed (April 19, 2021) ($40,000); UnitedHealthcare of Mid-Atlantic, Case No. Not Listed (April 19, 2021) ($40,000 penalty); UnitedHealthcare Ins. Co., Case No. Not Listed (April 22, 2021) ($40,000); Wellfleet Ins. Co., Case No. Not Listed (Nov. 8, 2021) ($40,000 penalty); CareFirst BlueChoice, Inc., Case No. Note Listed (May 21, 2021) ($75,000 penalty); CareFirst of Maryland, Case No. Not Listed (May 12, 2021) ($100,000); Group Hospitalization Medical Services, Case No. Not Listed (May 12, 2021) ($100,000 penalty).

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Carrier reimbursement data also demonstrate that MH and SUD providers are reimbursed at a lower rate than comparable medical services, which is a clear contributor to the inadequate MH and SUD provider networks.

- The Maryland Health Care Commission's 2019 analysis of 2017 data from the Maryland All-Payer Claims Database revealed that psychiatrists were paid less than three other medical specialties (primary care physicians, medical specialists, and surgeons) for the same four Evaluation and Management (E&M) Codes. **Some physicians received as much as 30% more than psychiatrists for the same billing codes and, in most cases, psychiatrists were paid below the Medicare benchmark while the other three physician specialists were paid at or above the Medicare rate.** Attachment 4.
- Milliman, Inc. found that, in 2017, PPO plans reimbursed behavioral health providers in Maryland **18% less than medical providers**, relative to the Medicare rate, for comparable outpatient office visits. **Maryland was the 4th worst state in utilization of non-network services for outpatient MH and SUD office visits.** S. Melek, S. Davenport, T.J. Gray, "Addiction and Mental Health v. Physical Health: Widening Disparities in Network Use and Provider Reimbursement, App. B-20 at p. 53, available at https://www.milliman.com/insight/Addiction-and-mental-health-vs-physical-health-Widening-disparities-in-network-use-and-p.

SB 707 would address the impact of network gaps in the most limited way possible. It would apply to consumers who request approval to go to a non-participating provider based on the carrier's failure to offer services within a reasonable time and distance.

C. Federal and State Law Protects Consumers Against Balance Billing for Emergency Department Services and Maryland Reimbursement Rate Standards Have Not Disrupted Carrier Networks

1. No Surprises Act Prohibits Balance Billing Even Without Carrier Approval on Non-Network Services

Enactment of the federal No Surprises Act by Congress and Maryland's twelve-year history of protections against surprise billing by emergency departments and on-call hospital practitioners should inform deliberation on SB 707.

First, federal law now protects consumers from balance billing – **without carrier permission** – when they receive services from a non-network provider of emergency services and non-emergency services from nonparticipating providers at specific facilities. **Consumers deserve that same protection when they do all they can to find a network provider and receive carrier permission to use a non-participating provider.** That right is meaningless if the consumer must pay extra out-of-pocket costs through no fault of their own.

The cost burden harm should not fall on consumers when, nationally, carriers spend a miniscule amount on MH and SUD services relative to their total healthcare spending. Milliman found that between 2013 and 2017:

- "Carrier spending for MH treatment (excluding prescription drugs), as a percentage of total healthcare spending, has been consistent, between **2.2% and 2.4%**."
- "Spending for SUD treatment (excluding prescription drugs), as a percentage of total healthcare spending, has increased from **0.7% in 2013 to 0.9%** in 2017."

Milliman, https://www.milliman.com/insight/Addiction-and-mental-health-vs-physical-health-Widening-disparities-in-network-use-and-p at 7.

LEGAL ACTION CENTER 810 First St, NE, Suite 200, Washington, DC 20002 T 202.544.5478 F 202.544.5712 nationalpolicy@lac.org www.lac.org

2. Maryland's Assignment of Benefits Standards Have Not Destabilized Networks

Second, questions may arise as to whether requiring carriers to cover approved non-network services at no greater cost to the member would have the unintended consequence of "destabilizing" existing networks; spurring some providers to leave the network to receive a higher reimbursement rate. **There is no evidence that providers would leave or not join networks.** Network disruptions seem unlikely, as many MH and SUD providers **want to join carrier networks** but are either told that networks have sufficient providers or are offered reimbursement rates that are not adequate to provide quality services.

This same concern was raised in 2010 when the General Assembly adopted consumer payment protections for services delivered by on-call physicians and hospital-based physicians (Chapter 537, 2010 Laws of Maryland). **The Maryland Health Care Commission (MHCC) reviewed the impact of establishing a statutory reimbursement rate for physicians who accepted an assignment of benefits and put this concern to rest.** It found that the law:

- Eased the financial burden on patients by discouraging non-participating physicians from balance billing patients.
- Protected payment levels for non-participating physicians who also benefitted from "increased predictability in payments."
- Did not lead to a "systematic deterioration in networks….Some up and down fluctuations in network participation did occur by specialty [and were] more significant for smaller carriers….

Letter from Ben Steffen, Executive Director, Maryland Health Care Commission, to Governor O'Malley and Chairs Middleton and Hammen (Jan. 15, 2015) at 1-2.

Carriers must play their role in addressing Maryland's overdose and suicide epidemics and the long-term heightened need for MH and SUD services resulting from the COVID-19 pandemic. These dual epidemics – COVID and drug overdose and mental health crises – have had a particularly harsh and disproportionate impact on communities of color. Meeting state and federal obligations to provide network coverage for MH and SUD benefits is essential as state policymakers pursue multiple strategies to ensure access to care and more robust networks.

Thank you for considering our views, and we urge a favorable report on SB 707.

Ellen M. Weber, JD
Sr. Vice President for Health Initiatives
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202-607-1047 (c)
202-544-5478 Ext. 307

ATTACHMENT 1

Balance Billing Protections
Fifty State Survey

As of January 2022, seventeen (17) states protect plan members from balance billing for non-network services if a health plan does not have an adequate provider network. These provisions apply to non-health maintenance organization (HMO) plans.

State	Citation	Language
Arkansas	Ark. Admin. Code 054.00.106-5 (C) (2014)	In the event that a Health Carrier has an insufficient number or type of participating providers to provide a Covered Benefit, the Health Carrier shall ensure that the Covered Person obtains the Covered Benefit **at no greater cost to the Covered Person than if the benefit were obtained from a participating provider**.
California	Cal Health & Saf. Code § 1374.72(d) (2021).	If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, the health care service plan shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards. **The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.**
Colorado	Colo. Rev. Stat. Ann. 10-16-704(2)(a) (2020).	In any case where the carrier has no participating providers to provide a covered benefit, the carrier shall arrange for a referral to a provider with the necessary expertise and **ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers.**
Connecticut	Conn. Agencies Regs. § 38a-472f-3(a) (2018).	Each health carrier that delivers, issues for delivery, renews, amends or continues any individual or group health insurance policy or certificate in this state that uses a provider network shall: (6) Have an adequate process in place **to provide in-network levels of coverage from nonparticipating providers, without unreasonable travel or delay or unreasonable wait time for an appointment, when a participating provider is not available.**
Delaware	Del. Code Ann. tit. 18, § 3348(b) (2001).	All individual and group health insurance policies shall provide that if medically necessary covered services are not available through network providers, or the network providers are not available within

	18 DE ADC 1403-11.3.1.2	a reasonable period of time, the insurer, **on the request of a network provider, within a reasonable period, shall allow referral to a non-network physician or provider and shall reimburse the non-network physician or provider at a previously agreed-upon or negotiated rate. In such circumstances, the non-network physician or provider may not balance bill the insured.** Such a referral shall not be refused by the insurer absent a decision by a physician in the same or a similar specialty as the physician to whom a referral is sought that the referral is not reasonably related to the provision of medically necessary services. If a plan has an insufficient number of providers that are geographically accessible and available within a reasonable period of time to provide covered health services to enrollees, **the MCO shall cover non-network providers, and shall prohibit balance billing.**
Hawaii	Haw. Rev. Stat. § 431:26-103(c)(1) (2019). Note: Health carriers also have an obligation to specify and inform covered persons of the process by which they may request access to obtain a covered benefit from a nonparticipating provider under subsection (1). Haw. Rev. Stat. § 431:26-103(c)(2).	A health carrier shall have a process to ensure that a covered person **obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a nonparticipating provider,** or shall make other arrangements acceptable to the commissioner when: (A) The health carrier has a sufficient network but does not have a type of participating provider available to provide the covered benefit to the covered person or does not have a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or (B) The health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay.
Illinois	215 Ill. Comp. Stat. § 124/10(b)(6) (2017).	A provision ensuring that whenever a beneficiary has made a good faith effort, as evidenced by accessing the provider directory, calling the network plan, and calling the provider, to utilize preferred providers for a covered service and it is determined the insurer does not have the appropriate preferred providers due to insufficient number, type, or unreasonable travel distance or delay, the insurer shall ensure, directly or indirectly, by terms contained in the payer contract, **that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider.**
Maine	02-031-850 Me. Code R. § 7(B)(5) (2012).	In any case where the carrier has an insufficient number or type of participating providers to provide a covered benefit, **the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers**, or shall make other arrangements acceptable to the Superintendent.

Minnesota	Minn. Stat. § 62Q.58(4)(b) (2001).	If an enrollee receives services from a nonparticipating specialist because a participating specialist is not available, **services must be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received from a participating specialist.**
Mississippi	Miss. Admin. Code 19-3:14.05(1) (2011).	In any case where the health carrier has an insufficient number or type of participating provider to provide a covered benefit**, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers**, or shall make other arrangements acceptable to the commissioner.
Montana	Mont. Code Ann. § 33-36-201(2) (2003).	Whenever a health carrier has an insufficient number or type of participating providers to provide a covered benefit, **the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the covered benefit were obtained from participating providers** or shall make other arrangements acceptable to the department.
New Hampshire	N.H. Code R. Ins 2701.10(b) (2018).	Each health carrier shall ensure that covered persons may obtain a referral to a health care provider outside of the health carrier's network when the health carrier does not have a health care provider with appropriate training and experience within its network who can meet the particular health care needs of the covered person. Services provided by out-of-network providers shall be subject to the utilization review procedures used by the health carrier. **The covered person shall not be responsible for any additional costs incurred by the health carrier under this paragraph other than any applicable co-payment, coinsurance, or deductible**.
New York	N.Y. Ins. Law § 4804(a).	If an insurer offering a managed care product determines that it does not have a health care provider in the in-network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an insured, the insurer shall make a referral to an appropriate provider, pursuant to a treatment plan approved by the insurer in consultation with the primary care provider, the non-participating provider and the insured or the insured's designee, **at no additional cost to the insured beyond what the insured would otherwise pay for services received within the network.**
South Dakota	S.D. Codified Laws § 58-17F-6 (2011).	In any case where the health carrier has an insufficient number or type of participating provider to provide a covered benefit, the health **carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers**, or shall make other arrangements acceptable to the director.

Tennessee	Tenn. Code Ann. § 56-7-2356(c) (1998).	In any case where the managed health insurance issuer has no participating providers to provide a covered benefit, the managed health insurance **issuer shall arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from a network provider**.
Vermont	Vt. Code R. § H-2009-03(5.1)(K)(3) (2017).	Coverage required pursuant to this subsection shall be without any additional liability to the member whether the service is provided by a contracted or non-contracted provider. **The member shall not be responsible for any additional costs incurred by the managed care organization under the paragraph other than any copayment, coinsurance or deductible applicable to the level of coverage required by this subsection.**
West Virginia	W. Va. Code § 33-55-3(c)(1). Note: Health carriers also have an obligation to specify and inform covered persons of the process by which they may request access to obtain a covered benefit from a nonparticipating provider under subsection (1). W. Va. Code § 33-55-3(c)(2).	A health carrier shall have a process to assure that **a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a nonparticipating provider, or make other arrangements acceptable to the commissioner when**: (A) The health carrier has a sufficient network, but does not have a type of participating provider available to provide the covered benefit to the covered person, or it does not have a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or (B) The health carrier has an insufficient number or type of participating providers available to provide the covered benefit to the covered person without unreasonable travel or delay.

Please contact Ellen Weber (eweber@lac.org) or Deb Steinberg (dsteinberg@lac.org) with questions.

ATTACHMENT 2

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor

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INSURANCE
ADMINISTRATION

AL REDMER, JR.
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October 1, 2019

Delegate Shane E. Pendergrass
Chairman, Health & Government Operations Committee
House Office Building, Room 241
6 Bladen Street
Annapolis, MD 21401

Re: June 5, 2019 HGO Letter - House Bill 837 - Payments to Noncontracting Specialists and Noncontracting Nonphysician Specialists

Dear Shane,

This letter is in response to your June 5, 2019 letter to the Maryland Insurance Administration (MIA) in regards to providing the Health and Government Operations Committee ("HGO") with information to "ensure the General Assembly can begin to identify solutions that will address perceived gaps in provider networks for mental health and substance use disorder services."

Please find below answers to the questions in the order in which they were raised in the June 5th letter.

Question 1 - Steps taken since July 2018 to improve carrier compliance with the network adequacy reporting requirements, under COMAR 31.10.44.09, including any new reporting tools that the MIA has developed to facilitate the submission of carrier reports.

> Response – Initially, the MIA used the 2018 network adequacy filings to establish a baseline for each carrier. The MIA then contacted carriers prior to the July 1, 2019 filing deadline if the MIA uncovered any errors in the executive summary filing format from the 2018 filings. In 2019 there was overall improvement among carriers with limited exception. The MIA has developed a 9 step internal review process for 2019 that will be amended as needed in preparation for the 2020 filings and review process. The MIA has been proactive in posting executive summaries on its website at the following hyperlink: https://insurance.maryland.gov/Consumer/Pages/Network-Adequacy-Regulations-Information.aspx.

Please note that the executive summaries posted on the MIA's website are posted with the following disclaimer:

> "Please note: the information contained in the executive summary forms provided below has not yet been reviewed by MIA staff for accuracy or completeness. The preliminary information reported below may be subject to change after the MIA completes its review of the 2019 access plans."

In addition, the MIA is preparing a procurement for software to assist in its review of the network adequacy information. Also, attached as **Exhibits 1, 2, & 3,** are three Market Conduct Orders identifying a network adequacy issue and ordering each carrier to provide documentation.

Question 2 – Enforcement orders issued in the past two years for violations of referrals to specialists under § 15-830 of the Health Insurance Article.

Response – In the past two years the MIA has issued two Orders for the violation of § 15-830(d) of the Insurance Article, referrals to specialists. The carriers failed to process referrals to specialists within the time frame required by law. The Orders are attached to this letter as **Exhibits 4 and 5.**

Question 3 – Remedial action taken or waivers request made, including related information as required under COMAR 31.10.44.17.C.

Response - The MIA received 13 reports on time and 1 report after the July 1, 2019 due date. During its preliminary review, the MIA has determined that none of the filings are 100% compliant with the network adequacy regulations. The MIA continues its review of each filing and is corresponding with each carrier regarding the information contained in the filings.

Only one carrier submitted a waiver request which is also under review. The MIA is currently communicating with carriers regarding their failure to submit requests for waivers in an effort to determine why waiver requests were not filed.

Question 4 – Comments on reimbursement strategies implemented in Arkansas, Maine, Mississippi, Nebraska, New Hampshire, South Dakota, and Washington under the following statutory and regulatory citations including recommendations on whether similar strategies could be implemented in Maryland:

- Arkansas, 54 Ark. Code R. § 106-5(C);
- Maine, 2-031 Ch. 850 Me. Code R. § 7(b)(5);
- Mississippi, 19 Miss. Code. R. § Pt. 3 R. 14.05;
- Nebraska, Neb. Rev. Stat. § 44-7105;
- New Hampshire, N.H. Code Admin. R. Ann. Ins§§ 2701.04,
- South Dakota, 2701.1O; S.D. Codified Laws§ 58-17F-6; and
- Washington, Wash. Admin. Code§ 284-170-200;

Response – Each of the above-listed states have enacted laws providing that, in the event of an inadequate network of providers, a carrier must provide that covered persons receive services from non-participating providers at a cost no more than the covered person would have had to pay if he or she had received the benefit from a participating provider.

While the basic language is similar across the state laws, there are variations. The full descriptions are included below, but the variations include:

- Maine, Mississippi, and South Dakota allow carriers to make alternative coverage arrangements, provided the alternative meets with the approval of that state's Insurance Commissioner/ Superintendent/ Director.
- Nebraska requires the carrier to pay its usual and customary rate, or "an agreed upon rate."
- New Hampshire does not require reimbursement to a non-participating provider who has been excluded from the carrier's network for failing to meet credentialing standards.

Some states provide waivers, and others limit the requirement to managed care plans. In each instance, however, the burden is on the carrier to assure that the insured is not responsible for some or all of the additional cost incurred from receiving services from a non-participating provider.

The following are the specific state requirements in each of the seven states.

Arkansas -Ark. Admin. Code 054.00.106-5 (C)

> In the event that a Health Carrier has an insufficient number or type of participating providers to provide a Covered Benefit, the Health Carrier shall ensure that the Covered Person obtains the Covered Benefit at no greater cost to the Covered Person than if the benefit were obtained from a participating provider.

Maine
02-031 CMR Ch. 850, § 7 (b)(5)

> In any case where the carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the Superintendent.

Mississippi
19 Miss. Admin. Code Pt. 3 R. 14.05

A health carrier providing a managed care plan[1] shall maintain a network that is sufficient in numbers and types of participating providers to assure that all services to covered persons will be accessible without unreasonable delay.

* * *

In any case where the health carrier has an insufficient number or type of participating provider to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the commissioner.

Nebraska
Neb.Rev.St. § 44-7105 (l)(a)

A health carrier providing a managed care plan[2] shall maintain a network that is sufficient in numbers and types of providers to assure that all health care services to covered persons will be accessible without unreasonable delay.

* * *

In any case in which the health carrier has an insufficient number or type of participating provider to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit and the health carrier shall reimburse the nonparticipating provider at the health carrier's usual and customary rate or at an agreed upon rate.

New Hampshire
N.H. Code Admin. R. Ins. 2701.04 (d)

In any county in which compliance with Ins 1701.04(a) is required and in which a health carrier's[3] network is insufficient to meet one of the access standards in Ins 2701.06 and in which the carrier has not been

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[1] A managed care plan includes a plan operated by a licensed insurance company, hospital or medical service plan, health maintenance organization, or an employer or employee organization. The term does not include a plan operated by a licensed insurance company unless it contracts with other entities to provide a network of participating providers. *See* Miss. Code Ann. § 83- 41-403 (b) and (c).

[2] "Managed care plan means a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable deductible, coinsurance, or copayment level for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier." Neb.Rev.St.§ 44-7103 (14).

[3] A "health carrier" includes "an insurance company, a health maintenance organization, a health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services." N.H. Code Admin. R. Ins. 2701.03 (e).

granted an exception pursuant to Ins. 2701.08[4] or Ins. 2701.14[5], the health carrier shall cover services provided by a non-participating provider located within the applicable geographic area at no greater cost to the covered person than if the services were obtained from a participating provider. Coverage under this paragraph shall be subject to all other terms and conditions of the covered person's health benefit plan, including, but not limited to, referral and authorization requirements. Nothing in this paragraph shall be construed to require a health carrier to provide, coverage for services provided by a non-participating provider who has been excluded from the health carrier's network for failing to meet any applicable credentialing standards.

South Dakota
SDCL § 58-17F-6

In any case where the health carrier has an insufficient number or type of participating provider to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the director[6].

Washington
WAC 284-170-200 (5)

In any case where the issuer has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the issuer must ensure through referral by the primary care provider or otherwise that the enrollee obtains the covered service from a provider or facility within reasonable proximity of the enrollee at no greater cost to the enrollee than if the service were obtained from network providers and facilities.

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[4] A health carrier can request an exception to network adequacy standards for a variety of enumerated reasons, including that an insufficient number of qualified providers or facilities are available in the county to meet the standards, or that it is due to the refusal of a local provider to accept a commercially reasonable rate, fee, tenn, or condition, or that the service can be obtained through telemedicine or telehealth from a participating provider. *See* N.H. Code Admin. R. Ins. 2701.08 (a).

[5] Written requests to the New Hampshire Insurance Commissioner for waiver shall be granted if the waiver does not contradict the objective and intent of the network adequacy law. *See* N.H. Code Admin. R. Ins. 2701.014 (a).

[6] This law applies to a health carrier providing a "managed care plan." A managed care plan includes a plan operated by a licensed insurance company, hospital or medical service plan, health maintenance organization, or an employer or employee organization. The term does not include a plan operated by a licensed insurance company unless it contracts with other entities to provide a network of participating providers. *See* SD St. § 58-l 7F-l.

Question 4 continued - Recommendations on whether similar strategies could be implemented in Maryland.

Response - Notwithstanding that it is within the purview of the legislature to determine whether similar strategies should be enacted in Maryland, there are certain Maryland HMO and insurance laws that should be carefully considered.

For example, Insurance Article, Sections 19-710 and 19-710.1 prohibit a non-participating Maryland-licensed provider from balance billing an HMO member and require an HMO to reimburse a non-participating Maryland licensed provider a certain amount. Similarly, Insurance Article, Sections 14-205.2 and 14-205 prohibit certain non-preferred providers such as Maryland-licensed hospital-based physicians and on-call physicians who are not hospital based and may be licensed outside of Maryland, from balance billing certain insureds under certain circumstances and also require an insurer or nonprofit health service plan to reimburse a non-preferred hospital-based physician and on-call physician who is not hospital based the correct rate provided for by law under certain circumstances. Enacting similar laws as the seven states referenced could require an HMO or other carrier to pay the non-participating provider's full billed charge in order to ensure that the cost of the services are no greater to the member / insured than if those services were rendered by a participating provider.

Question 5 – Please provide the following information as applicable: (i) the reimbursement rate that each carrier pays for in-network services; (ii) if the carrier reimburses at a set percentage of the Medicare rate, the reimbursement percentage and the Medicare benchmark year; and (iii) if the carrier reimburses medical practitioners and mental health/substance use disorder practitioners at different rates, the different rates:

Response - The requested information is attached as **Exhibit 6**. This information was provided by Mr. Kenneth Yeates-Trotman, Maryland Healthcare Commission. Further reimbursement rate inquiries may be directed to Mr. Yeates-Trotman at (410)764-3557 or kenneth.yeates-trotman@maryland.gov.

Question 6 – Recommendations on what penalty structure may be used for a carrier that does not meet the State network adequacy standards or obtain a waiver of the standards.

Response – All penalties assessed by the MIA must be calculated according to Code of Maryland Regulations (COMAR) 31.02.04.02, a copy of which is attached for your convenience as **Exhibit 7.** The MIA recommends that the same regulation and penalty structure be used for a carrier that does not meet the State network adequacy standards or obtain a waiver of the standards.

If we can be of any further assistance, please do not hesitate to call or email Michael Paddy, Director of Government Relations at 410-468-2408 or michael.paddy@maryland.gov.

Sincerely,

Al Redmer, Jr.
Insurance Commissioner

Cc: **Delegate Bonnie Cullison**
Delegate Sheree Sample-Hughes
Lisa Simpson, Committee Staff

ATTACHMENT 3

Appointment Wait Time Satisfaction for Non-Urgent MH/SUD Services 2018-2021

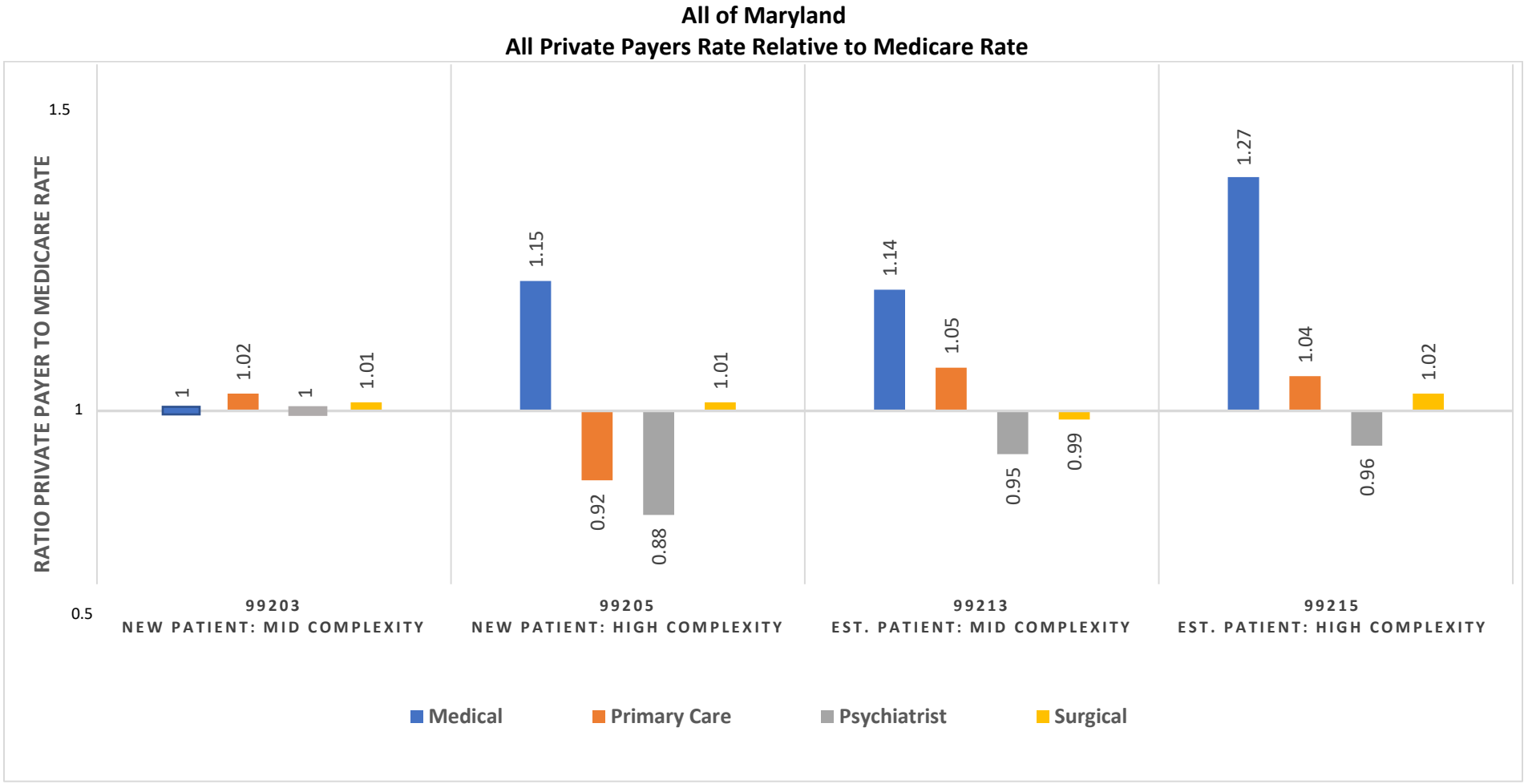
Carrier	2018 Report	2019 Report	2021 Report
Aetna Health Ins.	82% (in 14 days)	89%	72%
Aetna Life Ins. Co.	82% (in 14 days)	89%	72%
Aetna Health & Life Ins.	NA	NA	72%
CareFirst	95%	57.5%	98.1% PPO and HMO
CareFirst BlueChoice	95%	57.5%	98.1%
CareFirst GHMS	95%	57.5%	98.1% PPO and HMO
Cigna Life and Health Ins. Co.	Missing data	76%	100% (POS, OAP, PPO)
Connecticut Gen. Life Ins. Co.	Missing data	76%	NA
Golden Rule Ins. Co.	72%	96%	100%
Kaiser Found. Health Plan of Mid-Atlantic States	89.3%	84.3%	Not complete – 1 month count only
Kaiser Permanente Ins. Co.	Missing data	28%	80.48%
MAMSI Life and Health Ins. Co.	72%	96%	100%
Optimum Choice Inc.	72%	96%	100%
Optimum Choice Inc. Individual Exchange	NA	NA	100%
United Healthcare Ins. Co. Choice Plus	72%	96%	100%
United Healthcare Ins. Co. (CORE)	NA	96%	100%
United Healthcare of the MidAtlantic Inc. (CORE)	72%	96%	100%

United Healthcare of the MidAtlantic Inc. (Choice)	72%	96%	100%
United Healthcare of the MidAtlantic Inc. (Navigate)	NA	NA	100%
United Healthcare Navigate	NA	NA	100%
United Healthcare Nexus ACO	NA	NA	100%
United Healthcare Options PPO	NA	NA	100%
Wellfleet Insurance Co.	NA	NA	100% (PPO and OAP)

ATTACHMENT 4

Evaluation & Management Services: 2017 All Maryland Reimbursement Rates Relative to Medicare Benchmarks by Private Payer and Four Physician Specialties[1]

The reimbursement rate for psychiatrists was ***less than or equal*** to the Medicare allowed amount for four outpatient Evaluation & Management Codes (E&M) that are billed by medical, primary care, surgical and psychiatry specialties. In contrast, the reimbursement rate for the three other physician specialties exceeded the Medicare benchmark for most E&M codes. The reimbursement rate for psychiatry was less than the 3 other medical specialties listed for all E&M codes.



[1] Kenneth Yeates-Trotman, Maryland Healthcare Commission, Maryland All-Payer Claims Database. Prepared in response to June 5, 2019 HGO Letter – House Bill 837 – Payments to Noncontracting Specialists and Noncontracting Nonphysician Specialists (Oct. 1, 2019). All Private Payers includes CareFirst, United Healthcare, Aetna, and Cigna.

MCF_Fav_SB 707.pdf
Uploaded by: Haley Rizkallah
Position: FAV

SB 707 – Health Insurance – Provider Panels – Coverage for Non-participation

Committee: Senate Finance Committee
Date: February 23, 2022
POSITION: Support

The Maryland Coalition of Families: Maryland Coalition of Families (MCF) helps families who care for a loved one with behavioral health needs. Using personal experience, our staff provide one-to-one peer support and navigation services to family members with a child, youth or adult with a mental health, substance use or gambling issue.

MCF strongly supports SB 707.

We know that the mental health of children has been particularly hard hit during the COVID-19 pandemic. The CDC reported that the proportion of mental health-related ED visits increased sharply beginning in mid-March 2020 and continued into October (the study was completed in November 2020) with increases of 24% among children aged 5-11 years and 31% among adolescents aged 12-17 years, compared with the same period in 2019. Other indicators too show that the mental health of children has worsened during the pandemic. In the fall of 2021, a coalition of the nation's leading experts in pediatric health declared a national emergency in child and adolescent mental health.

Therefore not surprisingly, the number of families that have tried to access mental health treatment for their child has grown tremendously compared to pre-pandemic times. We often hear that parents/caregivers of children with private insurance have been told again and again, upon calling their carrier's in-network providers, that the providers are not taking new patients. At best, children wait for months on waiting lists to access mental health treatment. Families do not know that they have the right to request from their insurer that their child be allowed to see an out-of-network provider if no in-network provider can be found within a reasonable time and distance.

Not only do parents not know that they have this right, if they exercise that right they can be charged significantly more than their normal co-pay. The carrier bears no financial responsibility for having an inadequate network of providers.

SB 707 would remedy this unfair situation. First, families would be explicitly and clearly told that they have the right to see an out-of-network provider, and second, they would not bear

significant additional costs to exercise the right. Children would be able to access the mental health treatment that they so desperately need in a timely fashion.

For these reasons we request a favorable report on SB 707.

Contact: Ann Geddes
Director of Public Policy
The Maryland Coalition of Families
10632 Little Patuxent Parkway, Suite 234
Columbia, Maryland 21044
Phone: 443-926-3396
ageddes@mdcoalition.org

SB707.pdf
Uploaded by: Jessica Hasson
Position: FAV

TESTIMONY IN SUPPORT OF

Health Insurance – Provider Panels – Coverage for Nonparticipation (SB707)

Submitted by Dr Jessica Hasson, PhD, licensed psychologist
Paneled with various health insurers

February 22, 2022

Dear Chairperson and Respected Members:

I urge you to support Health Insurance – Provider Panels – Coverage for Nonparticipation (SB707). I am a licensed psychologist who works primarily out of Maryland. I am also licensed in Virginia, Washington DC, and I am a certified telehealth provider in Florida. Unlike many mental health providers in Montgomery County, I am paneled with various commercial health care plans and with Medicare. Please note my comments will be general so that I do not violate my contacts with health insurance panels.

Insurance companies will state they have sufficient providers to meet their consumers' needs. The mental health crisis proved this was simply not true. We, like many mental health providers, have a substantial waitlist. We have struggled to panel new providers we hired with insurance providers, sometimes waiting multiple months for the new provider to be approved. We also have attempted to panel with other providers, in order to offer services to the community, only to be told they have sufficient providers. Despite their assertion there are sufficient providers, we often hear from potential clients they cannot find a provider in their network with availability. This is partially due to "ghost networks," where providers are listed but either no longer working in network or do not have availability. Another contributing factor is the difficulty getting paneled, which limits provider availability.

Insurance companies pay below market rates. Combined with the difficulty getting paneled, the risk of "claw backs" where the insurance companies take back claims already paid out, and the possibility that services, and therefore payment, will be denied, paneling with insurance is not an attractive option.

At the same time, the lack of providers in network limits who can access mental health services. Although many mental health providers purport to offer "out of network benefits" there is no guarantee they have out of network coverage. This occurs frequently with consumers who are with HMO's rather than PPO's. Even if they have out of network benefits, there are often deductible associated with these benefits, resulting in clients having a large out of pocket cost that they would not have with in network providers.

For all the reasons cited above, I urge you to support SB707.

Respectfully Submitted,

Jessica Hasson, PhD
Licensed Psychologist
MD License #04976

MDDCSAM FAV Pmt Protection HB707.pdf
Uploaded by: Joseph Adams, MD
Position: FAV

Maryland-DC Society of Addiction Medicine
A Chapter of American Society of Addiction Medicine

MDDCSAM is the Maryland state chapter of the American Society of Addiction Medicine whose members are physicians and other health providers who treat people with substance use disorders.

SB 707 Health Insurance – Provider Panels – Coverage for Nonparticipation
Senate Finance Committee February 23, 2022

SUPPORT

Due to inadequate provider networks, members often have to request permission to get out-of-network behavioral health services.

Though carriers are required by law to provide these services, in practice they often do not.

One reason is that patients get **unexpected, unaffordable charges**, even though they **thought they were covered, pay their premiums, and asked permission** to go out of network.

But this is not the main problem.
The main problem is that members simply go without these covered services.

Many do not know what to do when there are no specialist in-plan providers.
They do not know they have to ask permission to go to another provider.
(And they don't know about the unexpected, possibly unaffordable new charges).

Even many healthy individuals would forego care due to these barriers.

The barriers becomes insurmountable for many experiencing mental health or substance disorder symptoms (in other words, people who need these services). These disorders often reduce energy, motivation, and affect the ability to function.

HB 912 requires that carriers inform members, in plain language, of the right to request treatment by a non-participating provider if needed, in print and electronic plan documents, and in any provider directory.

It also closes a gaping loophole whereby **covered members do not have access to services that they pay for and are entitled to.**

One of the greatest shortcomings in our system of care are well-known barriers to accessing behavioral health services. HB 912 would go a long way to restoring access, and restoring fairness.

Respectfully,
Joseph A. Adams, MD, FASAM, Chair, Public Policy Committee

15855 Crabbs Branch Way, Rockville, MD 20855 I mddcsam.org I info@mddcsam.org

NAMI - SB 707 - Provider Panels - FAV - 2022.pdf
Uploaded by: Josh Howe
Position: FAV

SB 707– Health Insurance - Provider Panels - Coverage for Nonparticipation

FAVORABLE

Chair Kelley and Members of the Finance Committee

The National Alliance on Mental Illness, Maryland and our 11 local affiliates across the state represent a statewide network of more than 45,000 families, individuals, community-based organizations, and service providers. NAMI Maryland provides education, support and advocacy for persons with mental illnesses, their families and the wider community.

SB 707 requires an insurer, nonprofit health service plan, health maintenance organization (HMO), dental plan organization, and any other person that provides health benefit plans to cover mental health or substance use disorder services provided by a nonparticipating provider at no greater cost to the member than if the services were provided by a participating provide.

NAMI supports SB 707 because we believe that health insurance should provide comprehensive mental health and substance use disorder coverage without arbitrary limits on treatment. NAMI supports establishment and enforcement of laws and policies that ensure parity between mental health and physical health services in all forms of insurance coverage.

Why We Care

There is no health care without mental health care. As such, it is critical for health insurance to provide comprehensive coverage of mental health and substance use disorder services. Yet, too often, health insurance covers mental health care differently than other kinds of medical services, creating barriers to affordable, accessible mental health care and reinforcing a stigma around mental illness and seeking mental health treatment.

Parity is the basic idea that mental health and addiction care are covered at the same level as care for other health conditions. State and federal laws have attempted to address discriminatory practices in health insurance by creating requirements around parity. In 1996, the Mental Health Parity Act (MHPA) was the first federal law to create parity standards, but only for annual and lifetime dollar limits. In 2008, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA) requiring comprehensive standards for equitable coverage of mental health and substance use disorder treatment and coverage of medical/surgical treatment. The 2010 Affordable Care Act (ACA) further expanded the reach of the parity laws by requiring most health plans cover mental health and substance use disorder care and expanding the scope of MHPAEA to reach most small group and individual markets. Additionally, states have enacted parity legislation to expand protections and/or improve compliance and enforcement of the federal laws. These efforts have helped create a more level playing field to treat mental and physical health conditions alike.

Kathryn S. Farinholt
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Moira Cyphers
Compass Government Relations
MCyphers@compassadvocacy.com

MATOD - SB 707 FAV - Consumer Payment Protection.p

Uploaded by: Joshua Grollmes

Position: FAV

c/o IBR/REACH Health Services
2104 Maryland Avenue
Baltimore, MD 21218

(410) 752-6080

www.matod.org

Senate Finance Committee
February 23, 2022

Senate Bill 707 - Health Insurance – Provider Panels – Coverage for Nonparticipation
Support

MATOD represents over 65 healthcare organizations across Maryland that provide and promote high-quality, effective medication assisted treatment for opioid addiction. We support Senate Bill 707, Consumer Payment Protection.

My name is Joshua Grollmes, and I am President of MATOD and a treatment provider. I have been in the substance use disorder (SUD) treatment field for 14 years and the organization I work with is in network with 3 major insurance carriers. We have been established since the early 2000s and were only able to get credentialed after hiring a company to do so on our behalf. This was a very expensive process that many new SUD/mental health providers are not able to afford until they have been established for many years. We tried to get the credentialing done in-house and gave up after many failed attempts. I believe this to be the primary reason many programs are unable to become credentialed with large insurance carriers.

Supporting this bill would benefit the consumer and the service providers. Many small, rural programs are not insurance experts and get run over when trying to get credentialed with large corporations. We didn't know about rate negotiations and would have been getting reimbursed a very different rate had we not hired an experienced credentialing person. Supporting this bill would close the gap and hopefully ensure that providers get reimbursed at an appropriate rate across the board. That would be for in-network and out-of-network providers.

COVID has dramatically increased the need for mental health and substance use disorder care in Maryland and being a small program in a rural area, we know treatment is much harder to find. We need to be more accessible to patients and passing this bill would be really beneficial.

Thank you.

Joshua Grollmes, MS
President

MATOD members include community and hospital based Opioid Treatment Programs, local Health Departments, local Addiction and Behavioral Health Authorities and Maryland organizations that support evidence-based Medication Assisted Treatment. MATOD members include thousands of highly trained and dedicated addiction counselors, clinical social workers, physicians, nurse practitioners, physician assistants, nurses, peer recovery specialists and dedicated staff who work every day to save and transform lives.

MRHA SB707- Health Insurance - Provider Panels - C

Uploaded by: Kathleen Hays

Position: FAV

Statement of Maryland Rural Health Association

To the Health and Government Operations Committee

February 23, 2022

Senate Bill 707- Health Insurance - Provider Panels - Coverage for Nonparticipating Providers

Position: SUPPORT

Chair Kelly, Vice Chair Feldman and members of the Finance Committee, the Maryland Rural Health Association (MRHA) wishes to provide this letter of information regarding SB 707- Health Insurance - Provider Panels - Coverage for Nonparticipating Providers.

Rural Maryland represents almost 80 percent of Maryland's land area and 25% of its population. Of Maryland's 24 counties, 18 are considered rural by the state, and with a population of over 1.6 million they differ greatly from the urban areas in the state. For example, networks of providers in rural Maryland are more limited and rural Marylanders frequently must travel farther to access health care services.

MRHA supports efforts to improve access to care for rural Marylanders and provided supportive testimony when this bill was before the committee in 2020. Since that time, workforce shortages and increased prevalence of behavioral health needs in our communities have become even more pronounced. This bill would have a positive impact on the communities we serve by removing purely administrative barriers to mental and behavioral health services.

MRHA's mission is to educate and advocate for the optimal health and wellness of rural communities and their residents. Membership is comprised of health departments, hospitals, community health centers, health professionals, and community members in rural Maryland.

Supporting initiatives that respond to rural health care workforce needs and enhancing access to behavioral health care are among our top advocacy priorities for this year. We believe this will improve suicide prevention, reduce overdose deaths and support parity of coverage for rural Marylanders and urge a favorable review.

Board President, Jennifer Berkman, 443-783-0480

Ellison_Fav_SB707.pdf
Uploaded by: Kelly Ellison
Position: FAV

SB 707 – Health Insurance – Provider Panels – Coverage for Non-participation

Committee: Senate Finance Committee
Date: February 17, 2022

POSITION: Support

I strongly support SB 707.

I needed a mental health provider for my child and contacted her private insurance company for assistance. The insurance company gave me a list of mental health providers, telling me that all of them were accepting new patients. The insurance company advised me to contact the provider(s) I was most interested in and go from there. I began to make phone calls only to find that each provider I called was not accepting new patients. When I contacted the insurance company again to see what I should do next, I was advised that I would have to access my ex-husband's Employee Assistance Plan for services. No one ever mentioned to me that I had the right to see an out-of-network provider since I was unable to get an appointment with an in-network provider.

I then attempted to find services at an alternate non-profit program that I was aware of, but due to the current overwhelming need within the community, I was turned away due to lack of availability. Finally, after a period of approximately 4 months, I was able to secure mental health services for my child through a grant program. During those four months while I was waiting to get an appointment with a mental health provider, my daughter's behavior continued to worsen. Her inability to self-regulate her emotions, anger outbursts and a general lack of coping skills negatively impacted her everyday living. Although her situation did not escalate to the point of requiring crisis intervention, the delay in accessing services impacted mine and her life dramatically.

SB 707 would remedy this indefensible situation. Families would be explicitly told that they have the right to see an out-of-network provider, at no additional cost to themselves. Children would be able to access the mental health treatment that they so desperately need in a timely fashion, and families would be able to afford the treatment. I request a favorable report on SB 707.

Kelly Ellison
130 W Claiborne Rd., #302
North East, MD 21901
443-350-1356
kellelle518@gmail.com

SB707-CBH-FAV.pdf
Uploaded by: Lori Doyle
Position: FAV

Testimony on SB 707
Health Insurance – Provider Panels – Coverage
For Nonparticipation
House Health and Government Operations Committee
February 23, 2022
POSITION: SUPPORT

The Community Behavioral Health Association of Maryland (CBH) is the leading voice for community-based providers serving the mental health and addiction needs of vulnerable Marylanders. Our 95 members serve the majority of those accessing care through the public behavioral health system. CBH members provide outpatient and residential treatment for mental health and addiction-related disorders, day programs, case management, Assertive Community Treatment (ACT), employment supports, and crisis intervention.

There continue to be significant barriers to behavioral health provider participation in commercial carrier networks; most of these revolve around low reimbursement for services and challenges with the carrier credentialing process. Two national studies conducted by Milliman showed Maryland to be close to the bottom of states in terms of its high percentage of consumers accessing mental health and substance use disorder benefits from out-of-network providers. This places the financial onus on consumers who pay their premiums but still can't access the care they need without additional – and often significant – out-of-pocket spending. Many must forego treatment or limit its frequency simply because they can't afford to pay for the care.

This bill would require carriers to inform their members of the right to request a referral to an out-of-network provider if their carrier has an insufficient number or type of providers with the expertise needed to serve a member seeking behavioral health care. Members would be able to choose an in-person or telehealth visit and would be subject to no greater out-of-pocket spending than if the provider were part of the carrier's network. The Maryland Health Care Commission would be tasked with establishing a reimbursement formula for nonparticipating providers, based on input from interested stakeholders.

It has now been over thirteen years since the federal Mental Health Parity and Addiction Equity Act passed in 2008, yet consumers in Maryland continue to foot the bill if they are unable to find needed behavioral health treatment within their carrier's network. It is time that we hold consumers financially harmless for the limitations of their carriers' provider networks.

We urge a favorable report for SB 707.

For more information contact Lori Doyle, Public Policy Director, at (410) 456-1127 or lori@mdcbh.org.

2020 LCPCM SB 707 Senate Side.pdf
Uploaded by: Lynn Kao
Position: FAV

LICENSED CLINICAL PROFESSIONAL COUNSELORS OF MARYLAND

Committee: **Senate Finance Committee**
Bill Number: **Senate Bill 707**
Title: **Health Insurance - Provider Panels - Coverage for Nonparticipation**
Hearing Date: **February 22, 2022**
Position: **Support**

The Licensed Clinical Professional Counselors of Maryland (LCPCM) strongly supports *Senate Bill 707 – Health Insurance - Provider Panels - Coverage for Nonparticipation.* This bill would require insurance carriers to cover behavioral health services at the same rate as an in-network provider if its provider panel has an insufficient number or type of participating specialists. The bill also requires notification of an individual's right to request a referral from an out-of-network specialist.

LCPCM has a long history of supporting efforts to increase network adequacy for behavioral health providers. This included supporting legislation in 2016 to establish network adequacy standards under the Maryland Insurance Administration. In addition, LCPCM supported legislation in 2018 and 2019 to ensure that licensed graduate professional counselors could be credentialed by insurance carriers.

Unfortunately, even with these developments, we still hear concerns from our members about the various barriers to becoming an in-network provider. We believe this bill will ensure that regardless of whether a provider is in-network or out-of-network, that individuals with behavioral health conditions get properly diagnosed and treated.

Thank you for your consideration of our testimony, and we urge a favorable vote. If we can provide any further information, please contact Scott Tiffin at stiffin@policypartners.net or 4443-350-1325.

2022 MOTA SB 707 Senate Side.pdf
Uploaded by: Lynn Kao
Position: FAV

Maryland Occupational Therapy Association

PO Box 131 ♦ Stevenson, Maryland 21153 ♦ mota.memberlodge.org

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 707 Health Insurance - Provider Panels - Coverage for Nonparticipation**

Date: **February 23, 2020**

Position: **Support**

The Maryland Occupational Therapy Association (MOTA) supports *Senate Bill 707 – Health Insurance - Provider Panels - Coverage for Nonparticipation.* This bill would require insurance carriers to inform members of their right to request a referral for a specialist who is not a part of the carrier's provider panel and require insurers to cover out-of-network behavioral health providers under certain circumstances.

Occupational therapists address barriers that individuals with mental health conditions experience in the community by providing interventions that focus on enhancing existing skills; remediating or restoring skills; modifying or adapting the environment or activity; and preventing relapse. As such, both the National Board for Certification in Occupational Therapy (NBCOT) and the American Occupational Therapy Association (AOTA) include mental health services within the scope of practice for occupational therapists. [1]

Unfortunately, carriers do not all consistently recognize occupational therapy practitioners as mental health providers. This bill would allow individuals with an opportunity to access occupational therapy services when there are not sufficient in-network occupational therapy practitioners. In addition, it is critical for consumers to be aware of their right to request a referral for appropriate mental health services as individuals may not be aware of what services are available for the treatment of a mental health condition.

Thank you for your consideration of our testimony, and we urge a favorable vote. If we can provide any further information, please contact Scott Tiffin at stiffin@policypartners.net or (443) 350-1325.

[1] National Board for Certification in Occupational Therapy – Certificate Renewal. https://www.nbcot.org/Certificants/Certification

American Occupational Therapy Association – Occupational Therapy's Role in Community Mental Health. https://www.aota.org/~/media/Corporate/Files/AboutOT/Professionals/WhatIsOT/MH/Facts/Community-mental-health.pdf

SB 707 - Health Insurance - Provider Panels - LOS.
Uploaded by: Michael Paddy
Position: FAV

Maryland
Hospital Association

February 23, 2022

To: The Honorable Delores G. Kelley, Chair, Senate Finance Committee

Re: Letter of Support – Senate Bill 707 – Health Insurance – Provider Panels – Coverage for Nonparticipation

Dear Chair Kelley:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on Senate Bill 707. Maryland hospitals and health systems care for millions of people each year. Central to this mission is ensuring the estimated one in five Marylanders suffering from mental health and substance use disorders have access to appropriate behavioral health care. However, efforts to place these patients at appropriate levels of care, particularly for post-discharge care, are often hindered by inadequate commercial insurer provider networks.

Maryland ranks fourth in the country for behavioral out-of-network use for office visits and 16th for inpatient facilities. Data show Marylanders with commercial, preferred provider organization plans are 10 times more likely to use an out-of-network provider for behavioral health office visits than medical/surgical office visits. Similarly, Marylanders are more than nine times more likely to use an out-of-network inpatient facility for behavioral health needs than medical/surgical needs.[1]

SB 707 would expand access to more mental health and substance use treatment providers by allowing patients to seek care outside of carrier networks and requiring carriers to fully honor their promise to the patient for coverage of medically necessary care. In this way, the bill could incentivize insurance carriers to begin appropriately including these providers in their networks and setting adequate reimbursement rates.

For these reasons, we urge a ***favorable*** report on SB 707.

For more information, please contact:
Michael Paddy, Director, Government Affairs
Mpaddy@mhaonline.org

[1] Milliman Research Report (Nov. 19, 2019). Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement.

NCADD-MD - SB 707 FAV - Consumer Payment Protectio
Uploaded by: Nancy Rosen-Cohen
Position: FAV

Senate Finance Committee
February 23, 2022

Senate Bill 707
Health Insurance - Provider Panels - Coverage for Nonparticipation

Support

NCADD-Maryland supports Senate Bill 707. Network adequacy problems among insurance carriers in Maryland persist despite attempts by the General Assembly and the Maryland Insurance Administration (MIA) to fix them. The results of the reviews of reports from the carriers to the MIA for the last few years have proved what we knew to be true, that carriers' networks are inadequate.

We know networks for mental health and substance use disorder services are particularly poor and the concern about consumers paying twice for their care when they get permission to go out of network due to this inadequacy have only increased during the pandemic.

Insurance carriers must do their part to address the opioid overdose crisis we are in – a crisis only exacerbated because of COVID. We believe this bill creates an appropriate incentive for carriers to expand their networks while ensuring that consumers have access to out of network providers when necessary without a financial penalty in the form of balance billing.

We urge a favorable report on Senate Bill 707.

The Maryland Affiliate of the National Council on Alcoholism and Drug Dependence (NCADD-Maryland) is a statewide organization that works to influence public and private policies on addiction, treatment, and recovery, reduce the stigma associated with the disease, and improve the understanding of addictions and the recovery process. We advocate for and with individuals and families who are affected by alcoholism and drug addiction.

National Council on Alcoholism & Drug Dependence – Maryland Chapter
28 E. Ostend Street, Suite 303, Baltimore, MD 21230 · 410-625-6482 · fax 410-625-6484
www.ncaddmaryland.org

OAG HEAU_FAV_SB0707.pdf
Uploaded by: Patricia O'Connor
Position: FAV

BRIAN E. FROSH
Attorney General

ELIZABETH F. HARRIS
Chief Deputy Attorney General

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STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
CONSUMER PROTECTION DIVISION

WILLIAM D. GRUHN
Chief
Consumer Protection Division

Writer's Direct Dial No.
(410) 576-6515

February 22, 2022

To: The Honorable Delores G. Kelley
Chair, Finance Committee

From: Patricia F. O'Connor, Health Education and Advocacy Unit (HEAU)

Re: Senate Bill 707 (Health Insurance - Provider Panels - Coverage for Nonparticipating Providers): Support

The Office of the Attorney General's Health Education and Advocacy Unit (HEAU) supports Senate Bill 707 because carriers would no longer be able to shift the costs of inadequate provider networks for mental health and substance use disorder (MH/SUD) benefits to their insureds. The Fiscal Note for the 2020 version of this bill stated on page 3 that "most carriers are not currently meeting at least some of the network adequacy standards for mental health and substance use disorder services," *see* link below, and the resulting lack of access to in-network care has been exacerbated by the pandemic. This bill proposes a feasible and fair solution.

<https://mgaleg.maryland.gov/2020RS/fnotes/bil_0005/hb1165.pdf>

Currently, unless the federal No Surprises Act balance billing protections apply[1], if an insured must go out of network because a carrier's network has an insufficient number or type of participating providers with the expertise to provide covered MH/SUD services to the insured within the appointment waiting time or travel distance standards established in regulations, the carrier does not accept responsibility for the balance bill. The balance bill is sent to the insured, who never bargained for that risk and who paid premiums in reliance on the contract to avoid that risk. The insured's deductible, copayment amount, or coinsurance is calculated as if the provider was in-network.

[1] Balance billing is prohibited when emergency services are provided by an out-of-network provider or facility and when services are provided by an out-of-network provider at an in-network facility (with limited exceptions when appropriate notice-and-consent is given.) 42 USC 300gg-111.

200 Saint Paul Place ♦ Baltimore, Maryland, 21202-2021
Main Office (410) 576-6300 ♦ Main Office Toll Free (888) 743-0023
Consumer Complaints and Inquiries (410) 528-8662 ♦ Health Advocacy Unit/Billing Complaints (410) 528-1840
Health Advocacy Unit Toll Free (877) 261-8807 ♦ Home Builders Division Toll Free (877) 259-4525 ♦ Telephone for Deaf (410) 576-6372
www.marylandattorneygeneral.gov

This bill would expressly require the carrier to cover the services provided by an out-of-network provider at no greater cost to the insured than if the services had been provided by an in-network provider.[2] In other words, consumers would get the benefit of the bargain they assume they are making when they purchase health insurance or receive it as an employment benefit, i.e., carriers are paid premiums in exchange for paying out MH/SUD claims when services are needed. An insured expects to pay only what he would have paid in an adequate network, and this bill would fulfill that expectation.

While HEAU believes that all consumers should be protected from balance billing in these situations, we support this incremental step to address Maryland's current behavioral health crisis.

We ask the committee for a favorable report.

cc: Delegate Sample-Hughes, Sponsor

[2] The 2000 and 2006 legislative history of Section 15-830 reflects intent for carriers whose plans in fact prove inadequate, to "bring" specialists into network for mandated referred care, at the carrier's expense, with the consumer in the same place he bargained to be – paying only what he would have paid in an adequate network.

MPA Testimony 2022 - Support - SB 707 - Health Ins

Uploaded by: Paul Berman

Position: FAV

MARYLAND
PSYCHOLOGICAL ASSOCIATION

10480 Little Patuxent Parkway, Ste 910, Columbia, MD 21044. Office 410-992-4258. Fax: 410-992-7732. www.marylandpsychology.org

February 21, 2022

Senator Delores G. Kelley, Chair
Finance Committee
Maryland Senate
3 East, Miller Senate Office Building
Annapolis, MD 21401

RE: SB 707 Position: SUPPORT

Dear Chair, Vice-Chair, and Members of the Committee:

The Maryland Psychological Association, (MPA), which represents over 1,000 doctoral level psychologists throughout the state, urges the Committee to provide a **favorable report on SB 707.**

Current law allows consumers with health insurance to go out of the network when the network panel cannot meet the subscriber's specific treatment needs or provide the services in a timely fashion. Unfortunately, current law does not specify the dollar amount the insurance company or the consumer is responsible for, and all too often this leads to cost-shifting by the insurance company with large co-pays for the consumer – even though the problem is that the insurance company does not have an adequate network (because of the low reimbursement rates set by the carrier which actively discourages network participation). **MPA strongly supports SB 707** because it clarifies that the consumer's financial responsibility in these specific situations would be no greater than what they would pay for an in-network therapist. We also believe that the Maryland Health Care Commission will set reasonable out-of-network rates that will fairly compensate therapists for their education, training, and expertise.

Simple economics reveals why many consumers cannot find therapists with needed skills and in a timely manner within the carrier's network. Most experienced psychologists cannot afford to belong to network panels. Insurance companies, on average, currently reimburse in-network psychologists $85 per session (with a range of about $70 to $120 per session). In 1990, more than 30 years ago, the average reimbursement for psychologists per session was $95. When you take inflation into account, $95 in 1990 is equivalent to $204 today. **In-network psychologists, therefore, are being asked to accept a non-negotiated rate set by the insurance company that is less than half (42%) of what they were being paid per session 30 years ago.**

SB 707 provides a reasonable remedy for consumers in these situations. SB 707 requires insurance companies to cover out-of-network therapy and substance abuse services **at no greater cost to the consumer** than they would pay to an in-network therapist when the carrier's panel does not have a therapist able to provide needed services in a timely fashion. For these and other reasons, the MPA urges you to **SUPPORT SB 707.**

Please feel free to contact MPA's Executive Director Stefanie Reeves at exec@marylandpsychology.org if we can be of assistance.

Sincerely,

Linda McGhee

Linda McGhee, Psy.D., JD
President

R. Patrick Savage, Jr.

R. Patrick Savage, Jr., Ph.D.
Chair, MPA Legislative Committee

cc: Richard Bloch, Esq., Counsel for Maryland Psychological Association
Barbara Brocato & Dan Shattuck, MPA Government Affairs

SB 707 - Support - MPS WPS.pdf
Uploaded by: Thomas Tompsett
Position: FAV

February 17, 2022

The Honorable Delores G. Kelley
Senate Finance Committee
3 East – Miller Senate Office Building
Annapolis, MD 21401

RE: Support – SB 707: Health Insurance - Provider Panels - Coverage for Nonparticipating Providers

Dear Chairman Kelley and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strive through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS and WPS represent over 1000 psychiatrists and physicians currently in psychiatric training.

MPS/WPS support Senate Bill 707: Health Insurance - Provider Panels - Coverage for Nonparticipating Providers (SB 707) as prompt treatment is paramount for people experiencing a mental health crisis. This need for prompt treatment leads many insured Marylanders with mental health and substance use disorders to seek providers and facilities outside their health plan's inadequate networks. Under current law, Marylanders have the right to ask their health plan for a referral to care outside of their plan's network of providers if they cannot find a qualified provider, have to wait a long time for an appointment or have to travel a long distance for their appointment. Most people, however, have no idea that this right exists or how to access it. SB 707 requires carriers to inform their members and beneficiaries, in plain language, of the right to request a referral to a specialist or nonphysician specialist in print and electronic plan documents and any provider directory

In addition, when individuals exercise their rights and seek care outside of their plans' networks with their carrier's approval, those non-network providers may still bill for the cost of the treatment that the health plans do not cover. If those providers had been in-network, the plans would have covered the total cost of treatment. Thus, Marylanders seeking out-of-network mental health and substance use disorder treatment are billed twice, once for their insurance premiums and again for the out-of-network treatment. SB 707 would rightfully require health plans to pay the non-network provider a fair reimbursement rate for treatment allowing the patient to pay for just the cost of an in-network service.

The federal No Surprises Act, which recently took effect on January 1, 2022, protects people covered under group and individual health plans from receiving surprise medical bills, also known as a balance bill, when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. This Honorable Committee, though SB 707, can and should take the next step in combating balance billing by requiring plans to cover Marylanders who get approval from their carrier to go out of network for mental health and substance abuse treatment when their existing networks are inadequate

Finally, studies repeatedly show that, when faced with low availability of providers and long wait times, psychiatric patients are much more likely to seek treatment out of network, which imposes a financial burden on them, or they simply do without treatment altogether because it's too expensive. Insurance companies are failing to meet the requirements for network adequacy imposed by parity laws. SB 707 would not only provide relief to psychiatric patients, but incentivize insurance companies to make network participation more attractive to providers.

For all the reasons above, MPS and WPS ask the committee for a favorable report on SB 707. If you have any questions with regard to this testimony, please feel free to contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

Respectfully submitted,
The Maryland Psychiatric Society and the Washington Psychiatric Society
Legislative Action Committee

SB 707_Coverage for Nonparticipation_Oppose.pdf
Uploaded by: Allison Taylor
Position: UNF

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

February 23, 2022

The Honorable Delores G. Kelley
Senate Finance Committee
3 East, Miller Senate Office Building
11 Bladen Street
Annapolis, Maryland 21401

RE: SB 707 – Oppose

Dear Chair Kelley and Members of the Committee:

Kaiser Permanente regretfully opposes SB 707, Health Insurance – Provider Panels – Coverage for Nonparticipation.

Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for approximately 800,000 members. In Maryland, we deliver care to over 460,000 members.

The United States is facing a national shortage in the mental health workforce, which we believe is the primary issue limiting patient access – not provider rates. One in five American adults has a diagnosable mental illness, yet 115 million Americans live in designated mental health professional shortage areas where the population-to-provider ratio is at least 30,000 to 1 (20,000 to 1 for communities with unusually high needs). Future projections indicate the problem is likely to get worse, not better, as 57% of all actively practicing psychiatrists in the U.S. are older than 55 and are likely to retire within the next 5 to 10 years.

Kaiser Permanente is concerned that HB 912 would discourage providers from joining our network. Provider networks help control costs by agreeing to set limits on how much they charge for certain procedures. By partnering with doctors and hospitals to control costs, carriers are better positioned to offer plans with lower premiums. If a provider knows that they will receive the same out-of-network rate from every carrier, the provider may be less likely to come in-network.

Kaiser Permanente members receive the best in-network care in the state. The National Committee on Quality Assurance has rated Kaiser Permanente of the Mid-Atlantic States' (which includes Maryland) commercial, Medicaid, and Medicare health plans as among the top

[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

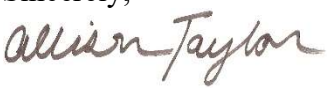
1% in the nation. As part of our commitment to total health, mental health care and addiction services are not limited to one department or specialty. Patients have access to health care and addiction services throughout Kaiser Permanente — including primary care, emergency care, and even specialty areas like cardiac and oncology. And in addition to clinical care and support, we offer self-care tools and resources that members can access anytime, at no cost.

Since this legislation was first introduced in 2020, Kaiser Permanente has substantially expanded patient access. We have opened three major medical facilities – Lutherville-Timonium Medical Center in Baltimore County, Bowie Fairwood Medical Center in Prince George's County, and Well by Kaiser Permanente in Montgomery County – and have plans to open additional facilities in the next few years. We have contracted with additional behavioral health providers and will begin seeing patients and two new hospitals later in 2022. Providers are always encouraged to apply to work with the Mid-Atlantic Permanente Medical Group or contract with Kaiser Permanente as a community provider.

Since that time, Kaiser Permanente has met the network adequacy waiting time standard for urgent care for 100% of patients and improved performance on the waiting time standard for non-urgent behavioral health services from 84.3% in 2019 to 99.1% in 2021, bringing us into compliance with the 95% threshold required by that regulation. These results demonstrate that improvements in our network lead to greater access for our patients, and we are proud of this important achievement.

Kaiser Permanente remains committed to providing high quality and timely behavioral health services. Thank you for the opportunity to comment. Please feel free to contact me at Allison.W.Taylor@kp.org or (202) 924-7496 with questions.

Sincerely,



Allison Taylor
Director of Government Relations
Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.